Women with dissociative identity disorder (DID) are significantly more likely than other women to experience intimate partner violence (IPV). The purpose of this qualitative investigation was to explicate the experiences of women with DID who experience IPV and describe how they cope. Grounded theory was used to conduct this investigation. Purposive sampling was used to recruit participants (N = 5) for face-to-face, semi-structured interviews. Verbatim transcripts were coded and categorized, and reflective memos were developed to explicate substantive categories. Women with DID used coping strategies that were consistent with their diagnoses, such as switching and dissociating. These coping mechanisms reflect past self-preservation strategies that were developed in association with severe childhood maltreatment. Women with DID who experienced IPV sought to mitigate and safeguard themselves from danger using strategies they developed as maltreated children. Nurses can use these findings to better recognize and understand the motivations and behaviors of women with DID who experience IPV. [Journal of Psychosocial Nursing and Mental Health Services, xx(x), xx-xx.]
control of an individual’s consciousness (APA, 2013). Due to the prevalence of child maltreatment, it is estimated that a diagnosis of DID affects approximately 1% of the population (>3 million Americans), making DID as common as schizophrenia (Brand, Loewenstein, & Lanius, 2014).

All forms of child maltreatment (i.e., physical, sexual, emotional, psychological maltreatment; witnessing intimate partner violence [IPV]) are well-documented risk factors for exposure to IPV in adulthood, which can lead to exacerbated mental illness symptoms, increased incidence of psychiatric hospitalization, and increased suicidality (Lalor & McElvaney, 2010). It is estimated that one of four women will experience IPV at some point in her life (Black et al., 2011). In the United States, approximately 200,000 women are raped and 1.3 million women physically assaulted by an intimate partner each year (Black et al., 2011).

Following child maltreatment, quantitative findings suggest that dissociation plays a role in increasing the risk of experiencing IPV as an adult (Webermann, Brand, & Chasson, 2014). Prior to the current investigation, no known qualitative research had been conducted to explore the relationship between DID and IPV. Therefore, current knowledge relating to women with DID who experience IPV may not be accurate or sufficient. This lack of research is particularly concerning because the incidence of IPV among survivors of childhood maltreatment is approximately double that of the general population (Arnow, 2004; Webermann et al., 2014).

**CONCEPTUAL FRAMEWORK**

Betrayal trauma theory (BTT; Freyd, 1994) was used as a framework for this investigation. BTT (1994) explicates the need for individuals who experience child maltreatment to develop dissociative amnesia for overwhelming abuse and neglect experiences to survive. Survivors are often dependent on abusers for basic needs (e.g., food, shelter), so it behooves them not to retaliate against abusers and risk worsening the maltreatment. BTT was appropriate for this investigation because it relates to the unique dissociative experiences of women with DID as an adaptive survival mechanism. BTT was used to develop interview questions, analyze data, and evaluate findings.

**SPECIFIC AIMS**

The primary aim of this qualitative inquiry was to explicate coping processes of women with DID who have experienced IPV. The goal was to collect enough meaningful data on these coping processes to inform a relevant theory. The secondary aim was to describe experiences of women with DID and factors that contribute to continued engagement in abusive relationships in adulthood.

**METHOD**

Grounded theory was used to conduct the current investigation. Prior to beginning data collection, the study was approved by the Health Sciences Institutional Review Board at the University of Missouri-Columbia and Sheppard Pratt Health System, a private psychiatric hospital in the Northeastern United States.

**Sampling**

Purposive sampling was used to recruit participants. To be included in the study, women were required to be IPV survivors, diagnosed with DID, English-speaking, and 18 or older. In addition, participants were diagnosed with DID by experts in the field in accordance with guidelines in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013). To aid in the diagnostic process, the *Structured Clinical Interview for DSM-IV Dissociative Disorders Revised* (SCID-D-R; Steinberg, 1994) was used, which is the current gold standard. For safety reasons, individuals were excluded from the current study if they had been psychiatrically hospitalized within 1 year of the study and/or if they were not currently under the care of an outpatient clinician (e.g., therapist, psychiatrist, psychologist).

**Recruitment**

Participants were referred to the researcher by psychiatrists, psychologists, and therapists who treat women with DID at a private psychiatric hospital in the Northeastern United States. These DID and IPV experts assisted the researcher with recruiting women the experts knew well and who had been stable in outpatient treatment for ≥1 year. Stability criteria included minimal dissociation, a high level of communication, and cooperation among personality states, as well as no psychiatric hospitalizations for ≥1 year.

Clinicians provided potential participants with the researcher’s contact information, and participants contacted the researcher by telephone and e-mail about participating in the study. The researcher then ensured inclusion criteria were met and scheduled an appointment to enroll the individual in the study. The researcher met participants in a private office at the local private psychiatric hospital. The researcher explained the study, answered the participants’ questions, and obtained written consent from participants.

**Data Collection**

Consultations and individual interviews with the researcher’s doctoral committee and DID/IPV experts were conducted to develop and refine interview questions while considering concepts from BTT (Freyd, 1994). Sample interview questions are presented in Table 1.

Data were collected by the researcher via face-to-face interviews in a private office at the local private psychiatric hospital. Follow-up telephone interviews were completed with four of the five participants to obtain clarification and discuss emerging themes. All tape-recorded interviews were semi-structured and guided by open-ended questions. Initial interviews were an average of 55 minutes (range = 48 to 72 minutes), and follow-up telephone interviews were an
average of 18 minutes (range = 11 to 22 minutes). Each participant received a copy of the consent, a safety card containing referral information for women who experience IPV, a list of local IPV resources and telephone numbers, and a $30 gift card for participating.

Data Analysis

All recordings were transcribed by the researcher, and coding and categorizing were completed using electronic tables. Sample codes and categories are shown in Table 2. Open coding was conducted, and basic core concepts emerged. Codes were then iteratively grouped together to form categories (i.e., axial coding). Memoing occurred throughout the data analysis process to further explicate categories (Richards & Morse, 2013). During data analysis, the researcher noted emerging codes and concepts that were consistent with BTT (Freyd, 1994) and made an effort to inquire further about these codes in subsequent interviews.

Validity

All researchers bring personal thoughts, emotions, philosophies, assumptions, and experiences to the table when conducting research. To conduct a valid study despite these factors, the researcher must be self-aware, acknowledge the impact personal beliefs may have on the research being conducted, and take steps to avoid bias (Berger, 2013). To ensure validity, the researcher used reflexivity to examine potential researcher bias throughout all stages of data collection and analysis (Berger, 2013; Doyle, 2013). In addition, validity was enhanced based on the richness of interview data. Follow-up telephone calls allowed the

---

### TABLE 1

<table>
<thead>
<tr>
<th>Sample Interview Questions</th>
<th>Interview Guide Samples</th>
</tr>
</thead>
</table>
| **Initial face-to-face interview** | - Describe resources you have used to cope with abusive intimate partners.  
- Describe factors that you think might contribute to your exposure to abusive intimate partner relationships.  
- Describe barriers that prevent you from leaving abusive intimate partner relationships.  
- If you had a magic wand, what resources would you create for women like yourself who have had similar experiences? |
| **Follow-up telephone interview** | - Several women interviewed mentioned that a barrier to leaving an abusive partner is an intense fear of abandonment that they feel stems from their childhood abuse. Do you think that applies to your experiences?  
- If yes, can you talk more about that?  
- Another theme that emerged in the interviews was chaos and confusion, internally and externally. Can you talk more about how this theme might apply to your experiences? |

### TABLE 2

<table>
<thead>
<tr>
<th>Sample Link Between Category, Codes, and Data</th>
<th>Select Codes</th>
<th>Select Examples from the Data</th>
</tr>
</thead>
</table>
| **Child maltreatment and its impact** | Fear of abandonment | - Dreading being alone  
- Lacking a family  
- Having an incomplete family |
| | Child maltreatment | - Having a broken home  
- Being a target  
- Witnessing abuse  
- Waiting for abuse |
| | Increased suicidality | - Worsening comorbidities  
- Increasing depression  
- Abusers blocking access to treatment |
RESULTS
Five participants completed the study. All were Caucasian women with an average age of 41 (range = 38 to 65 years). Two were divorced with a history of IPV, and two were married and currently experiencing IPV. One had a history of IPV but had never been married. Two women experienced IPV with multiple partners, and three women experienced IPV with a single partner. Self-reported comorbid mental illnesses within the sample included posttraumatic stress disorder (PTSD; n = 3), anorexia nervosa (n = 3), major depressive disorder (n = 3), obsessive-compulsive disorder (n = 1), and bipolar disorder (n = 1).

Analysis of the transcribed interviews resulted in the following substantive categories: childhood maltreatment and its impact, use of self-states to cope with IPV, worsening symptoms, and desire for resources.

Childhood Maltreatment and Its Impact
All participants reported severe childhood maltreatment by an immediate family member, including parents and siblings. Some reported abuse by unrelated individuals, which included ritual abuse and trafficking. All participants reported witnessing abuse in childhood, including IPV between parents, child maltreatment of siblings, and trafficking of other children. As a result, participants described the experience of lacking a family. As one participant stated, “There was no home.” The idea of a damaged, incomplete, or missing home was associated with a sense of increased vulnerability. One participant explained:

Being molested by a stepfather, being very abused by a brother, as far as physically. Very physically. A stepbrother molested me. Just a broken home. I mean, I was definitely seeking attention, so that made me more vulnerable, and so I definitely was a target [for an abuser].

Another participant described how her experience with her parents played a role in leading to an abusive relationship:

They were the only people I had ever associated with, and they were abusive, and I was trying desperately to get away from them. So, I jumped into the first relationship that came along, even though he was abusive.

Participants acknowledged that lacking family support, or having an outright abusive family, limited their options when experiencing IPV. As one participant stated, “I would not go back to my parents’ house, even though they were only 45 minutes away, because they’re abusive, too.” Another participant explained her situation:

I never had a family, so [being married to an abuser] gave me family security. You know, I never really had a mother or a father figure, so it just made me feel like a complete family, like I wasn’t abandoned or alone.

This intense fear of abandonment was a prominent theme throughout each interview. Participants described the unbearable fear of being alone as their “biggest horror,” even while enduring serious abuse and a partner’s infidelity. They reported being “so afraid and so obsessed” with the idea of being alone, even reporting recurrent nightmares of their partner abandoning them. As a result, fear of abandonment was cited as a major barrier to ending an abusive relationship.

Participants also endorsed the idea that abuse was familiar and expected, a notion due to the early onset and sustained experience of child maltreatment. After years of experiencing and witnessing abuse, participants came to view it as normal. As one participant put it, “I don’t think I noticed it [being hit by a partner] as being an odd thing.” Another said, “Just the fact of being used to being hit…I guess there are homes where people don’t scream at each other? It’s just really hard to believe.” One participant described realizing that abuse was not normal only through the experience of watching a popular talk show as an adult. In addition to the idea that abuse was normal and expected, participants discussed the implicit understanding that abuse was not to be talked about outside of the home, a belief that was carried into adulthood.

Use of Self-States to Cope with IPV
Participants used coping strategies for IPV consistent with the coping strategies they used for self-protection in childhood and that are associated with DID. Self-states, or “parts,” that developed as a result of overwhelming and intolerable childhood maltreatment were unconsciously and consciously called on to cope with IPV. For example, some participants described self-states that dealt with intimacy. “I had parts [self-states] that were assigned to have sex with him, but they were like trafficked parts and prostituted parts. And they always felt like they were being raped. It felt very much like sexual abuse.”

Others described switching to child self-states (e.g., hiding, curling up on the floor in tears) or aggressive, sometimes masculine, self-states (e.g., confronting, provoking, hitting the abuser) when experiencing verbal and physical abuse from a partner. Some participants expressed confusion and surprise at their varied reactions to IPV, particularly if they were unaware of the function of self-states and received their DID diagnosis after the abusive relationship had ended. Switching between self-states was a mechanism for participants to protect themselves and...
their self-states when they were unable to handle IPV.

Participants also developed new self-states as a result of IPV experiences. One participant explained:

“I’ve always had this experience with my mother and stuff like that, who was one of my abusers. She would scream at me, and I would be sort of like, sucked out of the room, and my brain would just feel like it was shattering into a million pieces. It just felt like I was splintering off, and it was just like the weirdest sensation. I sometimes get that with him [abuser], where I feel like new parts are breaking off and being created.

Another participant described the development of a new self-state when she met her abusive husband. This self-state loved the abuser unconditionally and had no memory of past abuse.

Conflicting beliefs among self-states were cited as impediments to ending and justifications for remaining in abusive relationships. Although some self-states may love an abuser, others may harbor extreme hatred and homicidal ideation toward the abuser, with a broad spectrum of feelings and beliefs in between the two extremes. One participant explained her experience: “There are parts that are going to die, believe will die, when he [abuser] walks out the door. I don’t know why they have more power than any other parts inside, but they do.” She went on to discuss how one particular self-state who loved her husband “unconditionally” begged him to come back after he left her for another woman.

Another participant described the chaos and confusion that can result from varying beliefs among self-states in the following manner: “When we’re [participant and her partner] fighting, especially internally, it just gets so chaotic with parts and all having different feelings about it and reacting different ways.”

Dissociation and Memory Impairments. All participants experienced increased dissociation and memory impairment during IPV, which is consistent with childhood coping mechanisms. By “disconnecting” or “going away” during episodes of abuse, participants were self-protecting. Paradoxically, this self-protection mechanism appeared to intensify conflict with an abusive partner. For instance, one participant stated: “I’m so disorganized, and I can never find anything or remember anything, so that causes fights.” Participants reported that in some cases, dissociation limited their ability to sense and flee from danger: “When I’m in a fight with him, I dissociate so badly, I know I cannot get behind the wheel [of a car].”

Worsening Symptoms

Experiencing IPV worsened the mental health of participants. As described previously, they experienced more frequent and rapid switching between self-states, formation of new self-states, increased dissociation and time loss, and more pronounced amnesia. Participants also reported increased suicidality and worsening of comorbid conditions such as depression and eating disorders. For example, one participant described increased “depression, self-hate, self-abuse” and “sleeping and smoking my head off.” Another woman described her own situation:

It activates my parts a lot. Probably still does cause new splintering. I’ve been very suicidal myself...and if I think about all the times he [abuser] told me I should do it [kill self] or how he would do it [kill participant]...that really doesn’t help my case very much. It feels like a jackhammer in my brain.

Abusers frequently used the women’s history of mental illness against participants and blamed them for problems in the relationship. For example, abusers would label participants as crazy, sick, forgetful, unreliable, and inconsistent. One participant recalled her abuser claiming: “I can’t trust you because you’re crazy. You have all these problems, so how do I know that anything you say is true?”

In some cases, abusers were intrusive in participants’ treatment and therapy or blocked participants’ access to mental health care, further limiting their coping options. As one participant stated, “He [abuser] was very angry the first time I got hospitalized [for an eating disorder]. He did not want me to go.” Another participant described her interactions with her abusive husband following her therapy sessions:

He would follow me...all around the house asking what I talked about in therapy. Saying things like, “You need to tell me because I’m the only one who can help you because I love you and I know you the best and she [therapist] doesn’t know you and she doesn’t care about you.”

Desire for Resources

When asked what they would create for other women like themselves if given a magic wand, participants requested resources to help cope with IPV. The most requested resources were more health care professionals trained to provide trauma-informed care for IPV survivors with DID. One participant said, “I don’t have any doctors who will see me or who know how to treat me. I wish.” Another participant stated:

So, after my last assault with [ex-husband], I went to two hospitals. First, I went to [the first hospital], and they didn’t do any tests or anything. They just let me go. They didn’t do any kind of screening. So, I was thinking, if there was more funding to train nurses about this kind of stuff, that would be good.

Another participant recommended “some kind of residential place where you could go with your kids and be safe. Not like a traditional shelter, but like a really nice comfortable safe place...where there’s treatment providers around.” This statement reflected participants’ overall dissatisfaction with traditional shelters. Other participants described shelters as “terrible” and “not helpful.” One woman stated:

I called the [local domestic violence shelter] during one of our bad times, and whoever answered the phone told me I couldn’t be serious. That this wasn’t something worthy of domestic violence, and I should be happy that it’s not a lot worse.

Other recommendations included
DISCUSSION

The experiences and coping strategies described in the current study are consistent with BTT (Freyd, 1994). According to Freyd (1994), children who experience maltreatment learn to respond to caregivers’ abuse and neglect in a passive way so that abuse will not worsen, particularly because children rely on caregivers for food, shelter, and other necessities. As such, children develop dissociative amnesia for trauma experiences, rather than fighting back. It is feasible that women with DID who experience IPV developed dissociative amnesia as maltreated children and may continue to do so when experiencing abuse as adults, thus extending the scope of BTT. The findings from the current study support this theory, indicating that women with DID experience increased dissociation and amnesia while in an abusive relationship.

Women with DID who experienced IPV reported multiple sources of perceived and actual danger, which could be abstract (e.g., fear of abandonment) or concrete (e.g., violent partner). Women sought to mitigate and safeguard themselves by using strategies similar to those they used for self-protection as maltreated children. Although these self-protection strategies may have been necessary for survival in childhood, they have the potential to make women more vulnerable to IPV in adulthood. For example, switching to a vulnerable, childlike self-state during IPV may limit women’s ability to detect danger and self-protect. Switching to an aggressive self-state during IPV may increase the risk for bidirectional IPV. Having multiple self-states with a variety of mixed feelings about an abuser further complicates the decision to leave or stay with an abuser.

Approximately 70% of individuals with DID attempt suicide as outpatients (APA, 2013), so exacerbated mental illness symptoms and increased suicidality resulting from IPV are critical concerns for individuals with DID. Lack of knowledge about the pathological process of DID tends to delay accurate diagnosis and treatment (International Society for the Study of Trauma and Dissociation, 2011). When appropriate treatment is delayed, women with DID may experience catastrophic outcomes.

IMPLICATIONS FOR PRACTICE AND RESEARCH

Practice

Women in the current study reported remaining in abusive relationships for many of the same reasons that are commonly cited in the literature: lack of housing, lack of transportation, financial dependency, desire to keep the family unit intact, child custody concerns, and concern for safety (Black et al., 2011; Bradbury-Jones, Taylor, Kroll, & Duncan, 2014; Webermann et al., 2014). Thus, nurses should take initiative to assess for DID and abuse in settings in which they are likely to encounter women at high risk for experiencing abuse, such as emergency departments. Nurses should inquire about a history of childhood maltreatment. Assessment should include questions about memory, amnesia, and time loss. For individuals known to have DID, nurses are urged to inquire about the frequency of switching between self-states, as well as the patient’s perceived control over switching. Due to the risk for increased mental health problems among abuse survivors, nurses should assess for increased self-harm impulses and suicidality. Nurses should also be alert for comorbidities, such as increases in depressive and/or eating disorder symptoms.

These assessments should be performed in a confidential, compassionate, and nonjudgmental manner. Autonomy is paramount, and nurses should respect the amount of information survivors are willing to disclose. Likewise, nurses should never pressure survivors for more information or to report or leave an abuser. Nurses should respect survivors’ readiness to make changes and follow up consistently in subsequent interactions or appointments, while offering reassurance and support. In addition, nurses are encouraged to become familiar with barriers experienced by IPV survivors with DID and be prepared to provide information on appropriate resources for support.

Dissociative disorders are not discussed extensively in the majority of pre-licensure nursing programs, so nurses may not feel comfortable working with individuals with these disorders (Loewenstein & Wait, 2008). Participants in the current study recommended increased training for nurses and other health care providers related to DID and empathic care for IPV survivors. Nurses would benefit from continuing education on DID and other dissociative disorders, including education on etiology, symptoms, prevalence, recommended interventions, and the factors that increase risk for experiencing IPV. Improved and widely available training in trauma-informed care may improve nurses’ ability to recognize and sensitively respond when treating individuals with DID.

Research

Additional qualitative research is warranted with a larger sample. A larger sample would allow for further development of the substantive categories that were identified in the current study. It would also allow for exploration of incidental evidence that emerged from this investigation, relating to potential intervention strategies (e.g., involvement of law enforcement, appointment of advocates, marriage counseling). Nurses are urged to remain abreast of current research related to trauma-informed care so they can make appropriate referrals to resources that will most benefit abuse survivors and women with DID.

All participants reported one or more comorbid mental health problems, with PTSD and anorexia nervosa.
being the most common (n = 3 for each). In addition to DID, it is possible that these comorbid conditions may have had an impact on participants’ coping with IPV. To improve care of women with DID who experience IPV, this confluence of diagnoses requires further investigation.

LIMITATIONS AND STRENGTHS

Limitations

The greatest limitation was the small sample. In addition, all participants were middle-aged, Caucasian women recruited from the same location. The small sample, homogeneity of the sample, and limited geographic scope compromise the transferability of the study findings. Recruiting and interviewing additional diverse participants would strengthen the quality of the study and improve the validity and transferability of the results.

Research relying on self-report is limited by the possibility of recall bias and incomplete or inaccurate participant responses, which may be compounded in a population of individuals with DID who have varying degrees of memory impairment. However, the women who participated in the current study appeared to be forthcoming when they were unable to remember details of an event or could not provide a complete answer to a question.

Strengths

Despite the limitations, findings from this investigation add valuable information to the existing literature on the experiences and coping strategies of women with DID. Middle-aged, Caucasian women are the population most likely to experience DID, so this investigation contributes important insights relevant to the experiences of the demographic (Brand et al., 2009). Overall, there is a dearth of literature relating to IPV survivors diagnosed with DID, and the findings from the current study have the potential to benefit this under-researched and difficult-to-reach population. The findings also provide direction for future research with this vulnerable group.

CONCLUSION

In addition to more commonly known coping mechanisms, women with DID use strategies consistent with their diagnosis of DID, such as switching and dissociating, to cope with IPV. These DID-specific coping mechanisms reflect past self-preservation strategies resulting from severe childhood maltreatment. To improve care for this vulnerable and underserved population, nurses are urged to become educated about dissociative disorders and recognize the potential need for adapted interventions and referrals. Finally, additional research is warranted to enhance the care of women with DID who experience IPV.

REFERENCES


Dr. Snyder is Assistant Professor, Towson University, Department of Nursing, Towson, Maryland.

The author has disclosed no potential conflicts of interest, financial or otherwise. This research was partially funded by the Jonas Center, the International Society for the Study of Trauma and Dissociation, and the University of Missouri-Columbia Sinclair School of Nursing.

The author thanks her doctoral advisor and doctoral committee for their support and guidance during this project: Dr. Deborah Finkfeld-Conn, Dr. Tina Bloom, Dr. Maithre Enriquez, and Dr. Kim Anderson.

Address correspondence to Briana L. Snyder, PhD, RN-BC, CNE, Assistant Professor, Towson University, Department of Nursing, 8000 York Road, Linthicum Hall 301, Towson, MD 21252; e-mail: bsnyder@towson.edu.

Received: August 6, 2017
Accepted: November 27, 2017

doi:10.3928/02793695-20180212-06